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Public Hearings on
"Medicaid Prescription Drugs:
Examining Options for Payment Reform"

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I am honored to testify in these hearings on "Medicaid Prescription Drugs: Examining Options for Payment Reform," held by the Committee on Energy and Commerce's Subcommittee on Health. I am a Resident Scholar at the American Enterprise Institute for Public Policy Research, where I have conducted research on pharmaceutical markets and other topics. The views I present are my own and do not necessarily represent those of the American Enterprise Institute.

1. Government Reimbursement Programs Often Create Cross-subsidies and other Distortions

It is only natural that the details of federal reimbursement programs will reflect the specific circumstances in which those programs are created. Such

details will inevitably create vested interests among both payers (who may realize savings not offered by the marketplace) and recipients (who may do better than they would in a competitive market). As conditions change, the program's essential features may persist because of these vested interests, even if a very different arrangement would emerge if the program were to be re-created under current conditions. As events proceed, very large inefficiencies can become very difficult to dismantle.

A common feature of such hide-bound systems is cross-subsidies, in which one set of parties receives compensation or reimbursement in excess of reasonable levels at the expense of other parties, whose own reimbursements may be enlarged to compensate for the cross-subsidies. Another common feature is that suppliers and other parties act in economically rational ways to take advantage of cross-subsidies, to reduce the burden of funding cross-subsidies, and so on. Over time, these reactions can substantially increase the scope and magnitude of distortions including cross-subsidies.

2. Cross-subsidies and Similar Mechanisms Greatly Complicate the Task of Setting Reasonable and Efficient Reimbursement Levels

In reasonably competitive private markets, affected parties tend to eliminate or contain cross-subsidies and similar distortions, or reduce their effects to manageable levels. Inefficient government reimbursement methods, however, often persist despite growing inefficiencies. As systems become more complex, essential elements become difficult or impossible to measure. Administrative costs in health care systems, for example, may change radically in the face of new technology, altered patient or physician preferences, and innovative organizational methods. The task of disentangling subsidies, cross-subsidies, and straight-forward reimbursement may become nearly impossible. Even the most competent analysts may find it impossible to construct accurate measurements of the magnitude or even the direction of cross-subsidies.

3. Eliminating or Minimizing Cross-subsidies Is Generally a Good Idea

Because managing the inefficiencies arising from cross-subsidies and related distortions in public reimbursement programs usually proves impossible in the long run, the best strategy is to eliminate cross-subsidies altogether. Assuming that private markets are not an alternative, a suitable goal is to assure that each party is reimbursed for acquisition and administrative costs in the most reasonable and feasible manner.

4. Federal Medicare and Medicaid Drug Reimbursement Programs Illustrate These Problems

It became apparent more than a decade ago that the Medicare Part B program, which among other things reimburses physicians for infusion drugs (mainly cancer treatments), systematically over-compensated physicians and clinics.¹ This engendered attempts by all parties to take advantage of the system, and even discouraged superior drug development because infusion products became favored over home-injectibles or even simple pills. A striking feature of this system was that sellers competed to provide products at less than the list prices upon which reimbursement rates were based, and employed marketing tools to make physicians aware of the benefits of prescribing brands with large reimbursement margins. The list prices that underpinned reimbursement rates were obtained from the “Average Wholesale Price” (or AWP) lists now published by Thomson Micromedex’s *Red Book* and First DataBank’s *Blue Book: Essential Directory of Pharmaceuticals*. All this was widely known at the time. A series of public hearings and reports starting in 1989 (U.S. Senate 1989), along with TV and other news stories (e.g., NBC News, Jan. 15, 1997), and a 1997 radio

¹ Useful sources include: MEDPAC 2003 (especially chap. 9); USGAO 2001; and USGAO 2002.

address by President Clinton, repeatedly highlighted the basic dynamics of a situation in which vested interests made it difficult to dismantle a cross-subsidy system. Only in the past year has Congress provided means for CMS to adopt a more direct cost-based reimbursement mechanism (CBO, December 2004; *Federal Register*, Jan. 7, 2004).

Recent reports from the Congressional Budget Office (December 2004 and June 2005a), the Government Accountability Office (February 2005), and the USDHHS Office of the Inspector General (September 2004) have made clear that similar trends have come to characterize Medicaid reimbursement for pharmaceuticals obtained by patients through retail pharmacies. Among these trends are increasing pharmacy margins. This in itself does not necessarily indicate a problem, but margins appear to have become unreasonably large for generic drugs, especially newer generics. This can be seen in Table 1, which is based on the December 2004 CBO report. Whereas average markups or margins increased from \$8.70 in 1997 to \$13.80 in 2002, prescriptions for newer generics involved average margins of \$32.10 in 2002. Such large disparities appear to make little sense because the actual costs of filling prescriptions are relatively consistent across the bulk of generic and branded drug.

Table 1
Medicaid's Prescription Drug Reimbursements, Wholesalers'
and Pharmacies' Acquisition Costs, and Margins, 1997 and 2002

	(all amounts in dollars per prescription)					
	Reimbursements to Pharmacies		Acquisition costs		Margins	
	1997	2002	1997	2002	1997	2002

All drugs	37.00	60.90	28.30	47.10	8.70	13.80
Generic drugs						
Newer	N/A	45.70	N/A	13.60	N/A	32.10
Older	11.90	14.20	4.30	4.40	7.60	9.90
Brand-name drugs	61.90	97.30	52.20	83.40	9.80	13.80

Source: All data are taken from Congressional Budget Office, "Medicaid's Reimbursements to Pharmacies for Prescription Drugs," December 2004, Table 1. N/A = not estimated because most "newer" generics were unavailable in 1997.

The June 2005 CBO report (CBO 2005a, p. 3) documents that the source of the large and growing disparities in pharmacy margins is the widespread practice among the states of basing reimbursement upon the same AWP lists that used to be the basis for Medicare Part B reimbursement. Although AWP price lists may once have been *bona fide* attempts to describe common transaction prices from wholesalers, it is well known that current list prices are often substantially above acquisition costs. As long as pharmacy reimbursement is based upon AWP, however, we can expect generic manufacturers whose drugs are available at prices substantially below AWP to make pharmacies aware of this fact and to encourage the filling of prescriptions with high-margin generics. The December 2004 CBO report indicates that this tendency is increasing, with substantial potential impact on overall Medicaid costs.

5. Alternatives to AWP for Reimbursement Purposes

I urge Congress and the states to reform the Medicaid drug reimbursement process to more closely reflect costs. Adopting a more accurate measure of drug acquisition costs is an essential part of this. The government reports cited above describe alternative acquisition cost indicators in some detail. The most promising

appears to be “average sales price,” or ASP. According to the June 2005 CBO report (n. 6), ASP is defined in the Medicare Modernization Act of 2003 as the average price charged to nonfederal buyers, taking into account volume discounts, prompt-pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates other than those paid under the Medicaid rebate program. Some of these adjustments, however, such as rebates and chargebacks, may be relatively unimportant for generics. Such adjustments are probably largely confined to the on-patent branded drug market, where large gaps between prices and manufacturing and marketing costs encourage private bargaining that can yield a substantial variation in prices among buyers of the same drug (cf. Frank 2001). In any case, however, the ASP measure, unlike AWP, is clearly tethered to actual market transactions and thus is not nearly as artificial as AWP prices. Basing reimbursement for drug acquisition on ASP prices would probably be a substantial improvement over the current system.

6. Pharmacy Reimbursement

The changes just outlined would require changes in how pharmacies are reimbursed for filling Medicaid prescriptions. Again, I suggest basing reimbursement largely on reasonable costs. In some situations, a simple percentage add-on may be appropriate. But a percentage markup can seriously distort incentives because the effect is to generate larger pharmacy margins for more expensive drugs regardless of the costs of filling prescriptions. This could distort Medicaid generic drug usage toward higher cost drugs with little or no off-setting benefit. It might make more sense to explore some mix of percentage and fixed-amount reimbursement if that can be achieved without introducing new and even larger distortions.

7. Pharmaceutical Acquisition Prices in Medicaid Are Already Low Enough

I also urge Congress and the states to avoid making further cuts in the prices paid by Medicaid to drug manufacturers. A series of measures in the past two decades has already pushed most of these prices below even the lowest private sector prices. This is because manufacturers, if they are to participate in Medicaid at all, must sell their drugs at prices that are usually adjusted below the “best price” in private sector sales (cf. CBO June 2005a, p. 11, and CBO June 21, 2005 on the increasing magnitude of “additional rebates” beyond meeting best-price levels in the private sector). This arrangement causes the Medicaid system to provide minimal payoffs for developing drugs to be used by the Medicaid population. In the long run, this could prove unfortunate. Certain conditions, notably schizophrenia, disproportionately afflict the Medicaid population (indeed, schizophrenia may be a prime reason why some people enter the Medicaid system in the first place). New drug development for these conditions is sorely needed. Even existing medicines can be cost-effective in the sense of moderating or even reducing overall Medicaid costs, and they may improve beneficiaries’ lives in ways that are otherwise difficult to achieve with patients who often defy traditional treatment. Steady reductions in the rewards for drug development for the Medicaid population are therefore inimical to advances in public health.

8. Cost-control: The fact that Medicaid pays relatively little for pharmaceuticals reduces the potential gains to be had from additional measures to control drug costs. Nonetheless, co-payments offer an obvious tool for cost control. Congress might consider granting the states expanded authority to use this tool. It would make sense to borrow from what has been learned by the private sector in its extensive experimentation with drug co-pays. Given that lower than normal co-pays would be appropriate for the typical Medicaid beneficiary, a nuanced approach could be useful. For some drugs, a significant co-pay on the order of three to ten dollars might cause patients to consider whether an expensive anti-

histamine, pain reliever, or anti-ulcer drug is worth the extra cost. For other drugs (such as anti-psychotics, perhaps, in addition to obvious candidates like vaccines), the Medicaid system might be better off if patients are encouraged by zero co-pays to fill their prescriptions and stick with their therapies.

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